		FOR OHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020131

Facility Name: JACKSONVILLE CONVALESCENT CENTER

Address: 1517 W. WALNUT (Number) JACKSONVILLE (City) 62650 (Zip Code)

County: MORGAN

Telephone Number: (217) 243 - 6451 **Fax #** (217) 243 - 8295

IDPA ID Number: 370983545001

Date of Initial License for Current Owners: AUGUST 1974

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** (217) 787 - 8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/04 to 06/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) JERRY W. JENNINGS
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	61	Skilled (SNF)	61	22,265	1
2		Skilled Pediatric (SNF/PED)			2
3	27	Intermediate (ICF)	27	9,855	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,120	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,091	4,091	8
9	SNF/PED					9
10	ICF	16,517	7,086		23,603	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,517	7,086	4,091	27,694	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.22%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/1974

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 61 and days of care provided 4,091

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/05 Fiscal Year: 6/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CEN' # 0020131 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	102,144	12,284	9,368	123,796		123,796		123,796			1
2	Food Purchase		120,404		120,404		120,404	(3,119)	117,285			2
3	Housekeeping	44,903	14,587		59,490		59,490		59,490			3
4	Laundry	25,883	7,149		33,032		33,032		33,032			4
5	Heat and Other Utilities			63,867	63,867		63,867		63,867			5
6	Maintenance	34,973	17,746	34,333	87,052		87,052	1,513	88,565			6
7	Other (specify):* **Utility Workers**	13,803			13,803		13,803		13,803			7
8	**TOTAL General Services**	221,706	172,170	107,568	501,444		501,444	(1,606)	499,838			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,205,870	250,212	74,588	1,530,670	(148,649)	1,382,021	8,695	1,390,716			10
10a	Therapy	59,391	4,478	315,761	379,630	(315,761)	63,869		63,869			10a
11	Activities	52,972	1,368		54,340		54,340		54,340			11
12	Social Services	22,291		4,469	26,760		26,760		26,760			12
13	CNA Training	1,364	35	931	2,330		2,330		2,330			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,341,888	256,093	407,749	2,005,730	(464,410)	1,541,320	8,695	1,550,015			16
	C. General Administration											
17	Administrative	57,933		10,019	67,952	2,460	70,412	41,459	111,871			17
18	Directors Fees											18
19	Professional Services			264,027	264,027		264,027	(253,817)	10,210			19
20	Dues, Fees, Subscriptions & Promotions			9,784	9,784		9,784	(4,449)	5,335			20
21	Clerical & General Office Expenses	39,952	11,644	5,340	56,936		56,936	31,164	88,100			21
22	Employee Benefits & Payroll Taxes			282,648	282,648		282,648	20,236	302,884			22
23	Inservice Training & Education			3,678	3,678		3,678	3,662	7,340			23
24	Travel and Seminar			6,535	6,535	(5,872)	663	624	1,287			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			71,621	71,621		71,621	429	72,050			26
27	Other (specify):*			53,039	53,039		53,039	(53,039)				27
28	**TOTAL General Administration**	97,885	11,644	706,691	816,220	(3,412)	812,808	(213,731)	599,077			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,661,479	439,907	1,222,008	3,323,394	(467,822)	2,855,572	(206,642)	2,648,930			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER #0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			28,986	28,986		28,986	9,178	38,164			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,412	4,412		4,412	(4,412)				32
33	Real Estate Taxes			26,542	26,542		26,542		26,542			33
34	Rent-Facility & Grounds			132,000	132,000		132,000	(126,764)	5,236			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			191,940	191,940		191,940	(121,998)	69,942			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					467,822	467,822		467,822			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,180	48,180		48,180		48,180			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			48,180	48,180	467,822	516,002		516,002			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,661,479	439,907	1,462,128	3,563,514		3,563,514	(328,640)	3,234,874			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,525)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,848	30		9
10	Interest and Other Investment Income	(599)	32		10
11	Discounts, Allowances, Rebates & Refunds	(118)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,456)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(470)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(250)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,527)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(46,333)	27		24
25	Fund Raising, Advertising and Promotional	(4,263)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule VENDING	(1,594)	2		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (60,287)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(268,353)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (268,353)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (328,640)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	Therapy	X		315,761	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		12,346	10	42
43	Prescription Drugs	X		106,310	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule Oxygen	X		27,045	10	45
46	Other-Attach Schedule Other Ancill	X		6,360	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 467,822		47

STATE OF ILLINOIS

JACKSONVILLE CONVALESCENT CENTER

ID# 0020131

Report Period Beginning: 07/01/04

Ending: 06/30/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,525)	0	0	0	0	0	0	0	0	0	0	(1,525)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,525)	0	0	0	0	0	0	0	0	0	0	(1,525)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	280	0	0	0	0	0	0	0	0	0	280	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,527)	(252,456)	0	0	0	0	0	0	0	0	0	(253,983)	19
20	Fees, Subscriptions & Promotions	(4,733)	175	0	0	0	0	0	0	0	0	0	(4,558)	20
21	Clerical & General Office Expenses	(118)	0	0	0	0	0	0	0	0	0	0	(118)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(280)	0	0	0	0	0	0	0	0	0	(280)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(53,039)	0	0	0	0	0	0	0	0	0	0	(53,039)	27
28	**TOTAL General Administration**	(59,417)	(252,281)	0	0	0	0	0	0	0	0	0	(311,698)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(60,942)	(252,281)	0	0	0	0	0	0	0	0	0	(313,223)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER **#** 0020131 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,848	4,314	0	0	0	0	0	0	0	0	0	7,162	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(599)	(3,813)	0	0	0	0	0	0	0	0	0	(4,412)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(132,000)	0	0	0	0	0	0	0	0	0	(132,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,249	(131,499)	0	0	0	0	0	0	0	0	0	(129,250)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(58,693)	(383,780)	0	0	0	0	0	0	0	0	0	(442,473)	45

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
H. RAYMOND KLEIN	25%	HILLTOP NURSING HOME, INC.	CHARLESTON	Nursing Home Mngrs	SPRINGFIELD	MANAGEMENT
SAM KLEIN	25%	MEADOW MANOR, INC.	TAYLORVILLE	J'ville Land Trust	SPRINGFIELD	LAND TRUST
DORYS BERG, TRUSTEE	50%	MENARD CONVALESCENT CENTER, INC.	PETERSBURG			
		SUNRISE MANOR OF VIRDEN, INC.	VIRDEN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	RENT	$ 132,000	JACKSONVILLE LAND TRUST	100.00%	$	$ (132,000)	1
2	V		30	DEPRECIATION		JACKSONVILLE LAND TRUST	100.00%	4,314	4,314	2
3	V		20	TRUST FEES		JACKSONVILLE LAND TRUST	100.00%	175	175	3
4	V		32	INTEREST		JACKSONVILLE LAND TRUST	100.00%	(252)	(252)	4
5	V		32	INTEREST		JACKSONVILLE LAND TRUST	100.00%	(3,561)	(3,561)	5
6	V									6
7	V		19	MANAGEMENT FEES	262,201	NURSING HOME MANAGERS, INC.	50.00%		(262,201)	7
8	V		VAR	SEE ATTACHED SCHEDULES		NURSING HOME MANAGERS, INC.	50.00%	115,427	115,427	8
9	V		19	ACCOUNTING		NURSING HOME MANAGERS - DIRECT ALLOCATION	50.00%	9,745	9,745	9
10	V		24	TRAVEL	280	TO TRANSFER 31% OF HOME OFFICE TRAVEL	50.00%		(280)	10
11	V		17	ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE - PER DESK REVIEW	50.00%	280	280	11
12	V									12
13	V									13
14	Total				$ 394,481			$ 126,128	$ * (268,353)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CEI # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	H. RAYMOND KLEIN	OWNER	MANAGEMENT	25.00					$ 2,381	17 - 7	1
2											2
3											3
4											4
5		H. RAYMOND KLEIN WAS PAID BY NURSING HOME MANAGERS, INC., A RELATED									5
6		ORGANIZATION. TOTAL COMPENSATION OF $10,010 WAS ALLOCATED AMONG									6
7		THE FIVE RELATED NURSING HOMES BASED UPON 10 HOURS PER WEEK FOR									7
8		H. RAYMOND KLEIN.									8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,381		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NURSING HOME MANAGERS, INC.
Street Address: 2653 WEST LAWRENCE - SUITE B
City / State / Zip Code: SPRINGFIELD, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE ATTACHED SCHEDULES				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number JACKSONVILLE CONVALESCENT CEN # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	J'VILLE LAND TRUST	X		WORKING CAPITAL		08/27/04	70,000	252,000	DEMAND	4.0000	3,561	6
7	BANK OF SPRINGFIELD		X	WORKING CAPITAL	INTEREST	05/25/05	112,000	157,000	05/25/06	6.0000	851	7
8												8
9	TOTAL Facility Related						$ 182,000	$ 409,000			$ 4,412	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 182,000	$ 409,000			$ 4,412	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER **#** 0020131 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	37,159	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	24,773	2
3. Under or (over) accrual (line 2 minus line 1).	$	(12,386)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	38,928	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	26,542	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2000	25,319	8
2001	26,027	9
2002	26,086	10
2003	24,773	11
2004	25,952	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

LINE 4: 2004 R E TAX BILL $ 25,952
6/12 OF $25,952= 12,976
LINE 4: TOTAL ACCRUAL 38,928

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME JACKSONVILLE CONVALESCENT CENTER COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0020131

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE (217) 787-8530 FAX #: (217) 787-9840

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-18-301-002	JACKSONVILLE CONV. CENTER	$ 25,952.02	$ 25,952.02
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 25,952.02	$ 25,952.02

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,061 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1974	$ 35,003	1
2	TITLE WORK		1989	426	2
3	TOTALS			$ 35,429	3

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1974	1974	$ 541,766	$ 2,245	30	$	$ (2,245)	$ 541,766	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			1975	3,850		5			3,850	9
10	AIR CONDITIONING / HEATING			1974	14,470		8			14,470	10
11	MOTORS			1980	533		5			533	11
12	BIDS			1981	739	22	30	25	3	607	12
13	FURNACE			1981	678		8			678	13
14	FAN			1981	972		15			972	14
15	USED AIR CONDITIONER			1982	2,000		8			2,000	15
16	VACUUM REPAIR - PER 1982 AUDIT			1982	1,031		10			1,031	16
17	FLOORING			1983	1,229		10			1,229	17
18	WATER HEATER			1983	1,498		8			1,498	18
19	WATER HEATER			1983	1,575		8			1,575	19
20	CEILING AND DOORS			1984	2,041		15			2,041	20
21	ASPHALT			1984	13,350		15			13,350	21
22	AIR CONDITIONING			1987	1,155		8			1,155	22
23	SIDEWALKS			1987	6,700	213	20	335	122	5,863	23
24	ROOF			1988	21,783	692	20	1,089	397	17,969	24
25	LIGHT DIFFUSER			1990	1,054	33	10		(33)	1,054	25
26	FLOORING			1990	1,030	33	15	68	35	997	26
27	WATER HEATER			1992	1,450	46	15	97	51	1,308	27
28	AIR CONDITIONING			1992	1,025		10			1,025	28
29	REWIRE FIXTURES			1992	1,110	35	10		(35)	1,110	29
30	COMPRESSOR			1993	1,479	38	10		(38)	1,479	30
31	DOOR STOPS			1993	2,168	55	15	145	90	1,660	31
32	ROOF			1993	34,178	876	20	1,709	833	19,652	32
33	FIRE DOORS			1996	1,011	26	15	67	41	637	33
34	WATER HEATER			1997	3,915	100	15	261	161	2,143	34
35	AIR CONDITIONING			1997	5,982	153	10	598	445	4,784	35
36	SWAMP COOLER			1998	1,125	29	8	141	112	1,010	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	1998	$ 1,950	$ 50	15	$ 130	$ 80	$ 877	37
38	DOOR ENTRANCE	1999	2,672	69	15	178	109	1,024	38
39	SHUTTERS	1999	912	23	15	61	38	345	39
40	DOOR ENTRANCE	2000	4,507	116	15	300	184	1,551	40
41	DUCT SMOKE DETECTORS	2000	2,295	59	20	115	56	565	41
42	DOOR	2000	2,280	59	15	152	93	722	42
43	ROOFTOP AIR CONDITIONER	2001	7,619	195	10	762	567	2,921	43
44	COMBUSTION AIR DUCT	2002	710	18	15	47	29	165	44
45	SMOKE DETECTORS	2002	2,511	64	15	167	103	543	45
46	GARAGE	2002	11,636	298	15	776	478	2,457	46
47	SMOKE DETECTORS	2002	809	21	15	54	33	171	47
48	FIRE DAMPERS	2002	1,166	30	15	78	48	247	48
49	ROOFTOP AIR CONDITIONER & HEATING (2)	2002	9,766	250	8	1,221	971	3,077	49
50	GARAGE INSULATION	2003	1,652	42	15	110	68	257	50
51	ROOFTOP AIR CONDITIONER & HEATING	2003	5,300	136	8	662	526	1,435	51
52	PARKING LOT	2003	13,306	341	15	887	546	1,626	52
53	VENTILATION	2004	4,380	112	15	292	180	316	53
54	SIDEWALK & CONCRETE PAD	2003	5,900	561	20	295	(266)	537	54
55	FENCE	2004	1,453	138	8	182	44	243	55
56	FIRE ALARM SYSTEM	2004	5,540	118	15	321	203	321	56
57	WATER HEATER	2005	2,673	26	15	74	48	74	57
58	ALARM SYSTEM	2005	4,171	40	15	116	76	116	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 764,105	$ 7,362		$ 11,515	$ 4,153	$ 667,036	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 179,845	$ 19,263	$ 16,480	$ (2,783)	Various	$ 91,390	71
72	Current Year Purchases	18,100	3,615	1,690	(1,925)	Various	1,690	72
73	Fully Depreciated Assets	153,628					153,628	73
74	Assets No Longer in Service	(77,603)					(77,603)	74
75	TOTALS	$ 273,970	$ 22,878	$ 18,170	$ (4,708)		$ 169,105	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT TRANSPORT	2003 FORD F350	2004	$ 28,203	$ 3,060	$ 6,463	$ 3,403	4	$ 6,463	76
77										77
78										78
79										79
80	TOTALS			$ 28,203	$ 3,060	$ 6,463	$ 3,403		$ 6,463	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,101,707	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 33,300	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 36,148	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,848	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 842,604	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: JACKSONVILLE LAND TRUST
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1974	88	08/01/74	$ 132,000			3
4	Additions							4
5								5
6								6
7	TOTAL		88		$ 132,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 07/01/04
    Ending 06/30/05

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	06/30/06	$ 132,000
13.	06/30/07	$ 132,000
14.	06/30/08	$ 132,000

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ Description: INCLUDED IN THE ABOVE AMOUNT
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 84

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER CNA 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			35		35
3	Classroom Wages	(a)		924		924
4	Clinical Wages	(b)		440		440
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments			831		831
8	CNA Competency Tests			100		100
9	TOTALS		$	$ 2,330	$	$ 2,330
10	SUM OF line 9, col. 1 and 2	(e)	$ 2,330			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 8	hrs	$	2,265	$	134,184	$	2,265	$ 134,184	1
2	Licensed Speech and Language Development Therapist	39 - 8	hrs		1,190		69,199		1,190	69,199	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 8	hrs		2,204		112,378		2,204	112,378	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 8	# of prescrpts					106,310		106,310	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): Lab,O2,Sup,OtherAnc	39 - 8						45,751		45,751	13
14	TOTAL			$	5,659	$	315,761	$ 152,061	5,659	$ 467,822	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER **#** 0020131 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 12,825	$ 21,702	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	640,409	640,409	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,549	18,549	6
7	Other Prepaid Expenses	1,314	1,314	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 673,097	$ 681,974	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		35,429	13
14	Buildings, at Historical Cost		658,844	14
15	Leasehold Improvements, at Historical Cost	104,230	104,230	15
16	Equipment, at Historical Cost	285,671	377,835	16
17	Accumulated Depreciation (book methods)	(219,525)	(928,932)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 170,376	$ 247,406	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 843,473	$ 929,380	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 147,876	$ 147,876	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	409,000	157,000	29
30	Accrued Salaries Payable	71,271	71,271	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,724	32,724	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,928	38,928	32
33	Accrued Interest Payable	155	155	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 699,954	$ 447,954	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 699,954	$ 447,954	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 143,519	$ 481,426	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 843,473	$ 929,380	48

***(See instructions.)**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 596,051	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 596,051	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(165,949)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Jacksonville Land Trust Income**	131,324	15
16	Other (describe) **J'ville Land Trust Distribution to Owners**	(80,000)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (114,625)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 481,426	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,404,593	1
2	Discounts and Allowances for all Levels	(127,078)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,277,515	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	114,131	6
7	Oxygen	75	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 114,206	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,383	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,525	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,908	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,224	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,224	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING	1,594	28
28a	W/A	118	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,712	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,397,565	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	501,444	31
32	Health Care	2,005,730	32
33	General Administration	816,220	33
	B. Capital Expense		
34	Ownership	191,940	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	48,180	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,563,514	40
41	**Income before Income Taxes (line 30 minus line 40)****	(165,949)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (165,949)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,760	1,880	$ 43,972	$ 23.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,347	5,561	117,368	21.11	3
4	Licensed Practical Nurses	23,557	24,600	429,237	17.45	4
5	CNAs & Orderlies	61,245	62,779	615,293	9.80	5
6	CNA Trainees	248	248	1,364	5.50	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,182	5,409	59,391	10.98	8
9	Activity Director	1,610	1,692	16,313	9.64	9
10	Activity Assistants	5,005	5,179	36,659	7.08	10
11	Social Service Workers	1,960	2,104	22,291	10.59	11
12	Dietician					12
13	Food Service Supervisor	1,970	2,149	26,070	12.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,777	10,110	76,074	7.52	15
16	Dishwashers					16
17	Maintenance Workers	3,671	3,839	34,973	9.11	17
18	Housekeepers	6,494	6,657	44,903	6.75	18
19	Laundry	4,010	4,126	25,883	6.27	19
20	Administrator	2,000	2,080	52,653	25.31	20
21	Assistant Administrator	256	376	5,280	14.04	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,001	4,201	39,952	9.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	2,314	2,345	13,803	5.89	33
34	TOTAL (lines 1 - 33)	140,407	145,335	$ 1,661,479 *	$ 11.43	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	288	$ 9,368	1 - 3	35
36	Medical Director	120	12,000	9 - 3	36
37	Medical Records Consultant	18	540	10 - 3	37
38	Nurse Consultant	967	45,251	10 - 3	38
39	Pharmacist Consultant	96	1,800	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	75	4,469	12 - 3	45
46	Other(specify) Utilization Review	46	4,650	10 - 3	46
47	Medicare Consultant	96	22,347	10 - 3	47
48	Administrative Consultant	304	10,019	17 - 3	48
49	TOTAL (lines 35 - 48)	2,010	$ 110,444		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Randolph	Administrator	0	$ 52,653
Dana Seymour	Asst. Administrator	0	5,280
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 57,933

B. Administrative - Other

Description	Amount
Administrative Consultant	$ 10,019
TOTAL (agree to Schedule V, line 17, col. 3)	$ 10,019
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Nursing Home Managers, Inc.	Management	$ 262,201
C S C	Corp. Representation	299
Feldman,Wasser,Draper&Benson	Legal	1,527
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 264,027

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,090
Unemployment Compensation Insurance	47,320
FICA Taxes	123,937
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Cafeteria - 125 Plan	60,380
Employee Life Insurance	3,567
Vaccine	2,183
Christmas Party	686
Gift Certificates	1,320
Employee Appreciation	165
Nursing Home Managers Allocation	20,236
TOTAL (agree to Schedule V, line 22, col.8)	$ 302,884

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Vaccine	22	$ 2,183
Christmas Party	22	686
Gift Certificates	22	1,320
Employee Appreciation	22	165
TOTAL		$ 4,354

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,890
Health Care Worker Background Check	1,008
(Indicate # of checks performed 63)	
Attached Schedule	4,886
J'ville Land Trust - Trust Fees	175
Nursing Home Managers Allocation	109
Less: Non-allowable Dues & Fees	(470)
Less: Public Relations Expense	(4,263)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,335

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Miscellaneous Mileage Reimbursement	663
Nursing Home Managers Allocation	624
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,287

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT	7/90 - 6/91	$ 1,384	3 YRS	$	$	$	$	$	$	$	$	$
2	INTERIOR PAINT	7/92 - 6/93	1,970	3 YRS									
3	WALLPAPER & PAINT	7/93 - 6/94	6,214	3 YRS									
4	WALLPAPER & PAINT	7/94 - 6/95	3,051	3 YRS									
5	WALLPAPER & PAINT	7/96 - 6/97	4,944	3 YRS									
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 17,563		$	$	$	$	$	$	$	$	$

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER **#** 0020131 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,833** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **48,180**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **1,525**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

PAGE 3 & 4 - SCHEDULE V

LINE 27 - GENERAL ADMINISTRATION - OTHER		
SALES TAX	$	6,456
BAD DEBTS		46,333
CONTRIBUTIONS		250
TOTAL LINE 27 - COLUMN 3	$	53,039

PAGE 3 & 4 - SCHEDULE V

DETAIL COLUMN 5 - RECLASSIFICATIONS			
			LINE #
RECLASS TO:			
NURSE CONSULTANT TRAVEL:	$	3,412	10
ADMINISTRATIVE CONSULTANT TRAVEL		2,460	17
RECLASS FROM: TRAVEL	$	(5,872)	24
RECLASS FROM:			
MEDICARE SUPPLIES	$	(1,888)	10
MEDICARE X-RAYS		(1,586)	10
MEDICARE DRUGS		(103,115)	10
MEDICARE LABORATORY FEES		(10,760)	10
MEDICARE I.V. THERAPY		(3,195)	10
OXYGEN		(27,045)	10
MEDICARE OTHER ANCILLARY SERVICES		(4,472)	10
PHYSICAL THERAPY		(112,378)	10A
SPEECH THERAPY		(69,199)	10A
OCCUPATIONAL THERAPY		(134,184)	10A
RECLASS TO: ANCILLARY SERVICES	$	467,822	39

PAGE 9 - SCHEDULE IX - LINE 6

INTEREST PAID TO JACKSONVILLE LAND TRUST IS OFFSET
SCHEDULE VII - SECTION B - LINE 5 - RELATED ORGANIZATI
AS PART OF JACKSONVILLE LAND TRUST INTEREST INCOM

PAGE 13 - SCHEDULE XI - SECTION E

RECONCILIATION OF DEPRECIATION		
LINE 83 - STRAIGHT LINE DEPRECIATION	$	36,148
NURSING HOME MANAGERS ALLOCATION		2,016
SCHEDULE V - LINE 30 - COLUMN 8	$	38,164

PAGE 15 - SCHEDULE XIII

AIDES TRAINED AT:
SUNRISE MANOR OF VIRDEN, INC.
333 SOUTH WRIGHTSMAN
VIRDEN, IL 62690

COST PER AIDE TRAINED - $415.40

ON PAGE 6
ION TRANSACTIONS
IE.

PAGE 19 - SCHEDULE XVII

RECONCILIATION OF INCOME	
NET INCOME - LINE 43	$ (165,949)
* MANAGEMENT FEE 6/30/04	(15,807)
* MANAGEMENT FEE 6/30/05	24,266
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	(1,224)
TAXABLE INCOME	$ (158,714)

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR TAX PURPOSES INCLUDED HERE FOR CONSISTENCY WITH PRIOR YEAR COST REPORTS AND TO CONFORM WITH ACCRUAL ACCOUNTING METHODS.

PAGE 21 - SCHEDULE XIX - SECTION F

DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS	
PUBLIC RELATIONS	$ 4263
CHAMBER OF COMMERCE DUES	295
FRANCHISE FEES	160
AUTOMOBILE LICENSE	168
	$ 4886

PAGE 23 - SCHEDULE XX

QUESTION #12

SALARY COSTS ARE ALLOCATED TO DEPARTMENT BASED UPON HOURS WORKED PER TIME CARDS.

CENTRAL OFFICE COST ALLOCATION
JACKSONVILLE
2004

	JULY 04	AUG	SEPT	OCT	NOV	DEC	JAN 05	FEB	MARCH	APRIL	MAY	JUNE	2004 TOTAL	LINE #
SALARIES-ADMIN	$3,465	$3,216	$3,086	$3,116	$3,195	$3,295	$3,348	$3,412	$3,326	$3,178	$3,065	$3,096	$38,798	17
SALARIES-CLERIC	2,397	2,419	2,321	2,343	2,403	2,478	2,404	2,450	2,388	2,282	2,201	2,223	28,309	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	
SALARIES-NURSE	613	931	894	902	925	954	599	610	595	568	548	554	8,695	10
ACCOUNTING	14	18	18	18	18	19	10	11	10	10	10	10	166	19
WORK COMP INS	20	24	23	23	24	24	21	22	21	20	20	20	262	22
SUPPLIES	130	106	102	103	106	109	113	116	113	108	104	105	1,314	21
TELEPHONE	132	135	130	131	134	138	148	151	147	140	135	137	1,659	21
EMPL BENEFITS	1,016	1,401	1,344	1,357	1,391	1,435	1,159	1,181	1,151	1,100	1,061	1,071	14,666	22
PAYROLL TAXES	470	416	399	403	413	426	479	488	476	455	439	443	5,308	22
TRAVEL	66	68	65	66	67	69	87	88	86	82	79	80	904	24
IN SERVICE	141	276	265	268	274	283	371	378	369	352	340	343	3,662	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	66	23	23	23	23	24	24	25	24	23	22	23	324	6
OWNERS COMP	205	201	193	195	200	206	204	208	202	193	186	188	2,381	17
INS-PROP,LIAB,WC	36	36	34	35	35	36	37	38	37	35	34	35	429	26
DEPRECIATION	181	170	163	164	169	174	172	175	170	163	157	159	2,016	30
RENT	451	430	412	416	427	440	458	467	455	435	420	424	5,236	34
MAINTENANCE	11	127	122	123	126	130	95	97	94	90	87	88	1,189	6
FEES & PUBLICAT	7	9	9	9	9	10	10	10	9	9	9	9	109	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	$9,424	$10,007	$9,601	$9,694	$9,939	$10,251	$9,739	$9,927	$9,677	$9,245	$8,916	$9,006	$115,427	
FIXED ASSETS													115,427	
EQUIP - PRIOR	10,506	5,214	5,002	5,051	5,178	5,341	14,623	14,905	14,529	13,881	13,387	13,523	10,095	
EQUIP - CURR	2,972	3,465	3,324	3,916	4,015	4,141	0	0	114	108	105	400	1,880	
EQUIP - FULLY DEP	4,753	9,328	8,949	9,036	9,264	9,555	4,712	4,803	4,682	4,473	4,313	4,357	6,519	
BLDG - PRIOR	1,674	1,595	1,530	1,545	1,584	1,634	1,660	1,692	1,649	1,576	1,519	1,535	1,600	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

JACKSONVILLE CONVALESCENT CENTER #0020131 PAGE 27 07/01/04 TO 06/30/05
MONTHLY CENTRAL OFFICE
COST ALLOCATIONS

NURSING HOME MANAGERS
COST ALLOCATION
JULY 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	19.21%	24.89%	17.15%	16.52%	22.23%	100.00%
SALARIES-ADMIN	$0	$2,674	$3,465	$2,387	$2,299	$3,094	$13,919
SALARIES-CLERIC	0	1,850	2,397	1,652	1,591	2,141	9,630
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	473	613	423	407	548	2,464
ACCOUNTING	0	11	14	10	10	13	58
WORK COMP INS	0	16	20	14	14	18	82
SUPPLIES	0	100	130	89	86	116	520
TELEPHONE	0	102	132	91	88	118	532
EMPL BENEFITS	0	785	1,016	700	674	908	4,083
PAYROLL TAXES	0	363	470	324	312	420	1,890
TRAVEL	0	51	66	46	44	59	266
IN SERVICE	0	109	141	97	94	126	568
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	51	66	45	43	58	263
OWNERS COMP	0	159	205	141	136	183	825
INS-PROP,LIAB,WC	0	28	36	25	24	32	145
DEPRECIATION	0	140	181	125	120	162	728
RENT	0	348	451	311	299	403	1,812
MAINTENANCE	0	9	11	8	7	10	45
FEES & PUBLIC	0	5	7	5	5	6	28
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,274	$9,424	$6,493	$6,253	$8,415	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	8,109	10,506	7,239	6,971	9,381	42,207
EQUIP - CURR	0	2,294	2,972	2,047	1,972	2,653	11,938
EQUIP - FULLY DEP	0	3,668	4,753	3,274	3,153	4,244	19,092
BLDG - PRIOR	0	1,292	1,674	1,153	1,111	1,495	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.68%	23.72%	17.45%	17.70%	22.45%	100.00%
SALARIES-ADMIN	$0	$2,533	$3,216	$2,366	$2,400	$3,044	$13,559
SALARIES-CLERIC	0	1,905	2,419	1,779	1,805	2,289	10,198
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	734	931	685	695	881	3,927
ACCOUNTING	0	14	18	14	14	17	78
WORK COMP INS	0	19	24	18	18	23	100
SUPPLIES	0	84	106	78	79	101	449
TELEPHONE	0	106	135	99	101	128	569
EMPL BENEFITS	0	1,103	1,401	1,030	1,045	1,325	5,904
PAYROLL TAXES	0	328	416	306	310	394	1,754
TRAVEL	0	53	68	50	50	64	285
IN SERVICE	0	218	276	203	206	261	1,165
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	18	23	17	18	22	99
OWNERS COMP	0	158	201	148	150	190	847
INS-PROP,LIAB,WC	0	28	36	26	27	34	150
DEPRECIATION	0	134	170	125	127	161	716
RENT	0	338	430	316	321	407	1,812
MAINTENANCE	0	100	127	93	95	120	535
FEES & PUBLIC	0	7	9	7	7	9	40
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,881	$10,007	$7,360	$7,466	$9,469	$42,185
FIXED ASSETS							
EQUIP - PRIOR	0	4,106	5,214	3,835	3,890	4,934	21,978
EQUIP - CURR	0	2,729	3,465	2,548	2,585	3,278	14,605
EQUIP - FULLY DEP	0	7,346	9,328	6,861	6,959	8,826	39,320
BLDG - PRIOR	0	1,256	1,595	1,173	1,190	1,510	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.79%	22.76%	17.64%	18.38%	22.43%	100.00%
SALARIES-ADMIN	$0	$2,548	$3,086	$2,392	$2,492	$3,041	$13,559
SALARIES-CLERIC	0	1,916	2,321	1,799	1,874	2,287	10,198
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	738	894	693	722	881	3,927
ACCOUNTING	0	15	18	14	14	17	78
WORK COMP INS	0	19	23	18	18	23	100
SUPPLIES	0	84	102	79	82	101	449
TELEPHONE	0	107	130	100	105	128	569
EMPL BENEFITS	0	1,110	1,344	1,042	1,085	1,324	5,904
PAYROLL TAXES	0	330	399	309	322	393	1,754
TRAVEL	0	54	65	50	52	64	285
IN SERVICE	0	219	265	206	214	261	1,165
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	19	23	17	18	22	99
OWNERS COMP	0	159	193	149	156	190	847
INS-PROP,LIAB,WC	0	28	34	27	28	34	150
DEPRECIATION	0	134	163	126	132	160	716
RENT	0	340	412	320	333	406	1,812
MAINTENANCE	0	100	122	94	98	120	535
FEES & PUBLIC	0	7	9	7	7	9	40
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,928	$9,601	$7,443	$7,753	$9,461	$42,185
FIXED ASSETS							
EQUIP - PRIOR	0	4,130	5,002	3,878	4,039	4,929	21,978
EQUIP - CURR	0	2,745	3,324	2,577	2,684	3,275	14,605
EQUIP - FULLY DEP	0	7,389	8,949	6,937	7,226	8,818	39,320
BLDG - PRIOR	0	1,264	1,530	1,187	1,236	1,508	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.83%	22.98%	17.43%	17.76%	23.00%	100.00%
SALARIES-ADMIN	$0	$2,553	$3,116	$2,363	$2,408	$3,118	$13,559
SALARIES-CLERIC	0	1,920	2,343	1,778	1,811	2,345	10,198
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	739	902	684	697	903	3,927
ACCOUNTING	0	15	18	14	14	18	78
WORK COMP INS	0	19	23	18	18	23	100
SUPPLIES	0	84	103	78	80	103	449
TELEPHONE	0	107	131	99	101	131	569
EMPL BENEFITS	0	1,112	1,357	1,029	1,048	1,358	5,904
PAYROLL TAXES	0	330	403	306	311	403	1,754
TRAVEL	0	54	66	50	51	66	285
IN SERVICE	0	219	268	203	207	268	1,165
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	19	23	17	18	23	99
OWNERS COMP	0	159	195	148	150	195	847
INS-PROP,LIAB,WC	0	28	35	26	27	35	150
DEPRECIATION	0	135	164	125	127	165	716
RENT	0	341	416	316	322	417	1,812
MAINTENANCE	0	101	123	93	95	123	535
FEES & PUBLIC	0	7	9	7	7	9	40
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,944	$9,694	$7,353	$7,491	$9,702	$42,185
FIXED ASSETS							
EQUIP - PRIOR	0	4,139	5,051	3,831	3,903	5,055	21,978
EQUIP - CURR	0	3,209	3,916	2,970	3,026	3,919	17,041
EQUIP - FULLY DEP	0	7,404	9,036	6,854	6,983	9,044	39,320
BLDG - PRIOR	0	1,266	1,545	1,172	1,194	1,547	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	19.18%	23.56%	17.23%	17.63%	22.40%	100.00%
SALARIES-ADMIN	$0	$2,600	$3,195	$2,337	$2,390	$3,038	$13,559
SALARIES-CLERIC	0	1,956	2,403	1,757	1,798	2,285	10,198
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	753	925	677	692	880	3,927
ACCOUNTING	0	15	18	13	14	17	78
WORK COMP INS	0	19	24	17	18	22	100
SUPPLIES	0	86	106	77	79	100	449
TELEPHONE	0	109	134	98	100	128	569
EMPL BENEFITS	0	1,132	1,391	1,017	1,041	1,323	5,904
PAYROLL TAXES	0	336	413	302	309	393	1,754
TRAVEL	0	55	67	49	50	64	285
IN SERVICE	0	223	274	201	205	261	1,165
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	19	23	17	17	22	99
OWNERS COMP	0	162	200	146	149	190	847
INS-PROP,LIAB,WC	0	29	35	26	26	34	150
DEPRECIATION	0	137	169	123	126	160	716
RENT	0	347	427	312	319	406	1,812
MAINTENANCE	0	103	126	92	94	120	535
FEES & PUBLIC	0	8	9	7	7	9	40
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$8,090	$9,939	$7,270	$7,436	$9,450	$42,185
FIXED ASSETS							
EQUIP - PRIOR	0	4,215	5,178	3,788	3,874	4,924	21,978
EQUIP - CURR	0	3,268	4,015	2,937	3,004	3,818	17,041
EQUIP - FULLY DEP	0	7,540	9,264	6,776	6,931	8,809	39,320
BLDG - PRIOR	0	1,290	1,584	1,159	1,185	1,507	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	20.13%	24.30%	17.51%	16.52%	21.54%	100.00%
SALARIES-ADMIN	$0	$2,729	$3,295	$2,374	$2,240	$2,921	$13,559
SALARIES-CLERIC	0	2,053	2,478	1,786	1,685	2,197	10,198
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	790	954	688	649	846	3,927
ACCOUNTING	0	16	19	14	13	17	78
WORK COMP INS	0	20	24	18	17	22	100
SUPPLIES	0	90	109	79	74	97	449
TELEPHONE	0	115	138	100	94	123	569
EMPL BENEFITS	0	1,188	1,435	1,034	975	1,272	5,904
PAYROLL TAXES	0	353	426	307	290	378	1,754
TRAVEL	0	57	69	50	47	61	285
IN SERVICE	0	234	283	204	192	251	1,165
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	20	24	17	16	21	99
OWNERS COMP	0	171	206	148	140	182	847
INS-PROP,LIAB,WC	0	30	36	26	25	32	150
DEPRECIATION	0	144	174	125	118	154	716
RENT	0	365	440	317	299	390	1,812
MAINTENANCE	0	108	130	94	88	115	535
FEES & PUBLIC	0	8	10	7	7	9	40
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$8,492	$10,251	$7,387	$6,969	$9,087	$42,185
FIXED ASSETS							
EQUIP - PRIOR	0	4,424	5,341	3,848	3,631	4,734	21,978
EQUIP - CURR	0	3,430	4,141	2,984	2,815	3,671	17,041
EQUIP - FULLY DEP	0	7,915	9,555	6,885	6,496	8,470	39,320
BLDG - PRIOR	0	1,354	1,634	1,178	1,111	1,449	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2005

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	22.02%	24.68%	17.22%	16.61%	19.46%	100.00%
SALARIES-ADMIN	$0	$2,988	$3,348	$2,336	$2,253	$2,639	$13,564
SALARIES-CLERIC	0	2,145	2,404	1,678	1,618	1,895	$9,739
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	534	599	418	403	472	$2,426
ACCOUNTING	0	9	10	7	7	8	$42
WORK COMP INS	0	19	21	15	14	17	$87
SUPPLIES	0	101	113	79	76	89	$459
TELEPHONE	0	132	148	103	100	117	$599
EMPL BENEFITS	0	1,034	1,159	809	780	913	$4,695
PAYROLL TAXES	0	428	479	334	322	378	$1,941
TRAVEL	0	77	87	61	58	68	$352
IN SERVICE	0	331	371	259	250	293	$1,504
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	22	24	17	16	19	$99
OWNERS COMP	0	182	204	142	137	161	$825
INS-PROP,LIAB,WC	0	33	37	26	25	29	$151
DEPRECIATION	0	153	172	120	115	135	$695
RENT	0	409	458	320	308	361	$1,857
MAINTENANCE	0	85	95	66	64	75	$385
FEES & PUBLIC	0	8	10	7	6	8	$39
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$8,691	$9,739	$6,797	$6,555	$7,678	$39,460
FIXED ASSETS							
EQUIP - PRIOR	0	13,049	14,623	10,205	9,842	11,528	59,248
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	4,205	4,712	3,288	3,171	3,714	19,091
BLDG - PRIOR	0	1,481	1,660	1,158	1,117	1,308	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2005

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	21.95%	25.16%	16.84%	16.31%	19.74%	100.00%
SALARIES-ADMIN	$0	$2,977	$3,412	$2,284	$2,213	$2,678	$13,564
SALARIES-CLERIC	0	2,138	2,450	1,640	1,589	1,923	$9,739
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	533	610	409	396	479	$2,426
ACCOUNTING	0	9	11	7	7	8	$42
WORK COMP INS	0	19	22	15	14	17	$87
SUPPLIES	0	101	116	77	75	91	$459
TELEPHONE	0	132	151	101	98	118	$599
EMPL BENEFITS	0	1,030	1,181	791	766	927	$4,695
PAYROLL TAXES	0	426	488	327	317	383	$1,941
TRAVEL	0	77	88	59	57	69	$352
IN SERVICE	0	330	378	253	245	297	$1,504
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	22	25	17	16	20	$99
OWNERS COMP	0	181	208	139	135	163	$825
INS-PROP,LIAB,WC	0	33	38	25	25	30	$151
DEPRECIATION	0	153	175	117	113	137	$695
RENT	0	408	467	313	303	367	$1,857
MAINTENANCE	0	84	97	65	63	76	$385
FEES & PUBLIC	0	8	10	6	6	8	$39
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$8,661	$9,927	$6,645	$6,437	$7,790	$39,460
FIXED ASSETS							
EQUIP - PRIOR	0	13,004	14,905	9,978	9,665	11,696	59,248
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	4,190	4,803	3,215	3,114	3,769	19,091
BLDG - PRIOR	0	1,476	1,692	1,133	1,097	1,328	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2005

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	21.98%	24.52%	17.26%	16.78%	19.44%	100.00%
SALARIES-ADMIN	$0	$2,982	$3,326	$2,342	$2,277	$2,637	$13,564
SALARIES-CLERIC	0	2,141	2,388	1,681	1,635	1,894	$9,739
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	533	595	419	407	472	$2,426
ACCOUNTING	0	9	10	7	7	8	$42
WORK COMP INS	0	19	21	15	15	17	$87
SUPPLIES	0	101	113	79	77	89	$459
TELEPHONE	0	132	147	103	101	117	$599
EMPL BENEFITS	0	1,032	1,151	811	788	913	$4,695
PAYROLL TAXES	0	427	476	335	326	377	$1,941
TRAVEL	0	77	86	61	59	68	$352
IN SERVICE	0	331	369	260	252	292	$1,504
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	22	24	17	17	19	$99
OWNERS COMP	0	181	202	142	138	160	$825
INS-PROP,LIAB,WC	0	33	37	26	25	29	$151
DEPRECIATION	0	153	170	120	117	135	$695
RENT	0	408	455	321	312	361	$1,857
MAINTENANCE	0	85	94	66	65	75	$385
FEES & PUBLIC	0	8	9	7	6	7	$39
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$8,675	$9,677	$6,813	$6,623	$7,673	$39,460
FIXED ASSETS							
EQUIP - PRIOR	0	13,025	14,529	10,229	9,945	11,520	59,248
EQUIP - CURR	0	102	114	80	78	90	463
EQUIP - FULLY DEP	0	4,197	4,682	3,296	3,204	3,712	19,091
BLDG - PRIOR	0	1,478	1,649	1,161	1,129	1,308	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2005

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	22.05%	23.43%	16.86%	16.56%	21.09%	100.00%
SALARIES-ADMIN	$0	$2,992	$3,178	$2,287	$2,247	$2,861	$13,564
SALARIES-CLERIC	0	2,148	2,282	1,642	1,613	2,054	$9,739
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	535	568	409	402	512	$2,426
ACCOUNTING	0	9	10	7	7	9	$42
WORK COMP INS	0	19	20	15	14	18	$87
SUPPLIES	0	101	108	77	76	97	$459
TELEPHONE	0	132	140	101	99	126	$599
EMPL BENEFITS	0	1,035	1,100	792	778	990	$4,695
PAYROLL TAXES	0	428	455	327	322	409	$1,941
TRAVEL	0	78	82	59	58	74	$352
IN SERVICE	0	332	352	254	249	317	$1,504
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	22	23	17	16	21	$99
OWNERS COMP	0	182	193	139	137	174	$825
INS-PROP,LIAB,WC	0	33	35	26	25	32	$151
DEPRECIATION	0	153	163	117	115	147	$695
RENT	0	409	435	313	308	392	$1,857
MAINTENANCE	0	85	90	65	64	81	$385
FEES & PUBLIC	0	9	9	7	6	8	$39
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$8,703	$9,245	$6,653	$6,536	$8,323	$39,460
FIXED ASSETS							
EQUIP - PRIOR	0	13,067	13,881	9,990	9,814	12,496	59,248
EQUIP - CURR	0	102	108	78	77	98	463
EQUIP - FULLY DEP	0	4,210	4,473	3,219	3,162	4,027	19,091
BLDG - PRIOR	0	1,483	1,576	1,134	1,114	1,418	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2005

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	22.20%	22.59%	17.54%	15.90%	21.77%	100.00%
SALARIES-ADMIN	$0	$3,012	$3,065	$2,379	$2,156	$2,953	$13,564
SALARIES-CLERIC	0	2,162	2,201	1,708	1,548	2,120	$9,739
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	539	548	426	386	528	$2,426
ACCOUNTING	0	9	10	7	7	9	$42
WORK COMP INS	0	19	20	15	14	19	$87
SUPPLIES	0	102	104	81	73	100	$459
TELEPHONE	0	133	135	105	95	130	$599
EMPL BENEFITS	0	1,042	1,061	823	746	1,022	$4,695
PAYROLL TAXES	0	431	439	340	309	423	$1,941
TRAVEL	0	78	79	62	56	77	$352
IN SERVICE	0	334	340	264	239	327	$1,504
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	22	22	17	16	22	$99
OWNERS COMP	0	183	186	145	131	180	$825
INS-PROP,LIAB,WC	0	34	34	27	24	33	$151
DEPRECIATION	0	154	157	122	110	151	$695
RENT	0	412	420	326	295	404	$1,857
MAINTENANCE	0	85	87	67	61	84	$385
FEES & PUBLIC	0	9	9	7	6	8	$39
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$8,761	$8,916	$6,921	$6,273	$8,589	$39,460
FIXED ASSETS							
EQUIP - PRIOR	0	13,154	13,387	10,392	9,418	12,897	59,248
EQUIP - CURR	0	103	105	81	74	101	463
EQUIP - FULLY DEP	0	4,239	4,313	3,348	3,035	4,156	19,091
BLDG - PRIOR	0	1,493	1,519	1,180	1,069	1,464	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2005

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	21.42%	22.82%	18.50%	15.47%	21.79%	100.00%
SALARIES-ADMIN	$0	$2,906	$3,096	$2,509	$2,098	$2,955	$13,564
SALARIES-CLERIC	0	2,086	2,223	1,802	1,506	2,122	9,739
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	520	554	449	375	529	2,426
ACCOUNTING	0	9	10	8	7	9	42
WORK COMP INS	0	19	20	16	13	19	87
SUPPLIES	0	98	105	85	71	100	459
TELEPHONE	0	128	137	111	93	131	599
EMPL BENEFITS	0	1,006	1,071	868	726	1,023	4,695
PAYROLL TAXES	0	416	443	359	300	423	1,941
TRAVEL	0	75	80	65	54	77	352
IN SERVICE	0	322	343	278	233	328	1,504
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	21	23	18	15	22	99
OWNERS COMP	0	177	188	153	128	180	825
INS-PROP,LIAB,WC	0	32	35	28	23	33	151
DEPRECIATION	0	149	159	129	107	151	695
RENT	0	398	424	343	287	405	1,857
MAINTENANCE	0	82	88	71	60	84	385
FEES & PUBLIC	0	8	9	7	6	8	39
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$8,453	$9,006	$7,300	$6,103	$8,597	$39,460
FIXED ASSETS							
EQUIP - PRIOR	0	12,693	13,523	10,961	9,163	12,908	59,248
EQUIP - CURR	0	375	400	324	271	381	1,751
EQUIP - FULLY DEP	0	4,090	4,357	3,532	2,953	4,159	19,091
BLDG - PRIOR	0	1,441	1,535	1,244	1,040	1,465	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

ALLOCATION PERCENTAGES USED ON
MONTHLY ALLOCATIONS - PAGE 27

OCCUPIED

DAYS 2004	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY		2,030	2,537	1,662		1,422	2,071	9,722
FEBRUARY		1,886	2,419	1,579		1,304	1,901	9,089
MARCH		1,904	2,594	1,733		1,438	2,148	9,817
APRIL		1,814	2,437	1,647		1,496	2,206	9,600
MAY		1,838	2,364	1,665		1,591	2,159	9,617
JUNE		1,847	2,285	1,683		1,547	2,088	9,450
JULY		1,881	2,437	1,679		1,617	2,176	9,790
AUGUST		1,861	2,363	1,738		1,763	2,236	9,961
SEPTEM		1,815	2,198	1,704		1,775	2,166	9,658
OCTOBER		1,897	2,315	1,756		1,789	2,317	10,074
NOVEMBER		1,855	2,279	1,667		1,705	2,167	9,673
DECEMBER		2,013	2,430	1,751		1,652	2,154	10,000
TOTAL	0	22,641	28,658	20,264	0	19,099	25,789	116,451
								116,451

OCCUPIED

DAYS 2005	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY		2,230	2,499	1,744		1,682	1,970	10,125
FEBRUARY		1,998	2,290	1,533		1,485	1,797	9,103
MARCH		2,199	2,453	1,727		1,679	1,945	10,003
APRIL		2,085	2,215	1,594		1,566	1,994	9,454
MAY		2,095	2,132	1,655		1,500	2,054	9,436
JUNE		1,942	2,069	1,677		1,402	1,975	9,065
JULY		2,118	2,026	1,781		1,315	1,994	9,234
AUGUST								0
SEPTEM								0
OCTOBER								0
NOVEMBER								0
DECEMBER								0
TOTAL	0	14,667	15,684	11,711	0	10,629	13,729	66,420
								66,420

ALLOCATION

PERCENTAGE 2004	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.00%	20.88%	26.10%	17.10%	14.63%	21.30%	100.00%
FEBRUARY	0.00%	20.75%	26.61%	17.37%	14.35%	20.92%	100.00%
MARCH	0.00%	19.39%	26.42%	17.65%	14.65%	21.88%	100.00%
APRIL	0.00%	18.90%	25.39%	17.16%	15.58%	22.98%	100.00%
MAY	0.00%	19.11%	24.58%	17.31%	16.54%	22.45%	100.00%
JUNE	0.00%	19.54%	24.18%	17.81%	16.37%	22.10%	100.00%
JULY	0.00%	19.21%	24.89%	17.15%	16.52%	22.23%	100.00%
AUGUST	0.00%	18.68%	23.72%	17.45%	17.70%	22.45%	100.00%
SEPTEMBER	0.00%	18.79%	22.76%	17.64%	18.38%	22.43%	100.00%
OCTOBER	0.00%	18.83%	22.98%	17.43%	17.76%	23.00%	100.00%
NOVEMBER	0.00%	19.18%	23.56%	17.23%	17.63%	22.40%	100.00%
DECEMBER	0.00%	20.13%	24.30%	17.51%	16.52%	21.54%	100.00%

ALLOCATION

PERCENTAGE 2005	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.00%	22.02%	24.68%	17.22%	16.61%	19.46%	100.00%
FEBRUARY	0.00%	21.95%	25.16%	16.84%	16.31%	19.74%	100.00%
MARCH	0.00%	21.98%	24.52%	17.26%	16.78%	19.44%	100.00%
APRIL	0.00%	22.05%	23.43%	16.86%	16.56%	21.09%	100.00%
MAY	0.00%	22.20%	22.59%	17.54%	15.90%	21.77%	100.00%
JUNE	0.00%	21.42%	22.82%	18.50%	15.47%	21.79%	100.00%